Notice of Allowability	Application No.	Applicant(s)	
	09/756,077	PROVOST ET AL.	
	Examiner	Art Unit	
	Carolyn M. Bleck	3626	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address--

All claims being allowable, PROSECUTION ON THE MERITS IS (OR REMAINS) CLOSED in this application. If not included herewith (or previously mailed), a Notice of Allowance (PTOL-85) or other appropriate communication will be mailed in due course. **THIS NOTICE OF ALLOWABILITY IS NOT A GRANT OF PATENT RIGHTS.** This application is subject to withdrawal from issue at the initiative of the Office or upon petition by the applicant. See 37 CFR 1.313 and MPEP 1308.

1. ☒ This communication is responsive to *31 January 2006*.

2. ☒ The allowed claim(s) is/are *1-27 and 36-40 (Now renumbered 1-32)*.

3. ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
   a) ☐ All b) ☐ Some* c) ☐ None of the:
      1. ☐ Certified copies of the priority documents have been received.
      2. ☐ Certified copies of the priority documents have been received in Application No. _____ .
      3. ☐ Copies of the certified copies of the priority documents have been received in this national stage application from the International Bureau (PCT Rule 17.2(a)).

   * Certified copies not received: _____.

Applicant has THREE MONTHS FROM THE "MAILING DATE" of this communication to file a reply complying with the requirements noted below. Failure to timely comply will result in ABANDONMENT of this application.
THIS THREE-MONTH PERIOD IS NOT EXTENDABLE.

4. ☐ A SUBSTITUTE OATH OR DECLARATION must be submitted. Note the attached EXAMINER'S AMENDMENT or NOTICE OF INFORMAL PATENT APPLICATION (PTO-152) which gives reason(s) why the oath or declaration is deficient.

5. ☐ CORRECTED DRAWINGS (as "replacement sheets") must be submitted.
   (a) ☐ including changes required by the Notice of Draftsperson's Patent Drawing Review (PTO-948) attached
      1) ☐ hereto or 2) ☐ to Paper No./Mail Date _____.
   (b) ☐ including changes required by the attached Examiner's Amendment / Comment or in the Office action of Paper No./Mail Date _____.

   Identifying indicia such as the application number (see 37 CFR 1.84(c)) should be written on the drawings in the front (not the back) of each sheet. Replacement sheet(s) should be labeled as such in the header according to 37 CFR 1.121(d).

6. ☐ DEPOSIT OF and/or INFORMATION about the deposit of BIOLOGICAL MATERIAL must be submitted. Note the attached Examiner's comment regarding REQUIREMENT FOR THE DEPOSIT OF BIOLOGICAL MATERIAL.

Attachment(s)

1. ☒ Notice of References Cited (PTO-892)
2. ☐ Notice of Draftperson's Patent Drawing Review (PTO-948)
3. ☐ Information Disclosure Statements (PTO-1449 or PTO/SB/08), Paper No./Mail Date _____
4. ☐ Examiner's Comment Regarding Requirement for Deposit of Biological Material
5. ☐ Notice of Informal Patent Application (PTO-152)
6. ☐ Interview Summary (PTO-413), Paper No./Mail Date _____ .
7. ☒ Examiner's Amendment/Comment
8. ☒ Examiner's Statement of Reasons for Allowance
9. ☐ Other _____.

JOSEPH THOMAS
SUPERVISORY PATENT EXAMINER

DETAILED ACTION

Notice to Applicant

1. A request for continued examination under 37 CFR 1.114, including the fee set forth in 37 CFR 1.17(e), was filed in this application after final rejection. Since this application is eligible for continued examination under 37 CFR 1.114, and the fee set forth in 37 CFR 1.17(e) has been timely paid, the finality of the previous Office action has been withdrawn pursuant to 37 CFR 1.114. Applicant's submission filed on 31 January 2006 has been entered.

2. Claims 1-21, 22-27, and 36-40 are pending. Claims 1, 6, 22, and 36 have been amended. Claim 40 is newly added.

EXAMINER'S AMENDMENT

3. An examiner's amendment to the record appears below. Should the changes and/or additions be unacceptable to applicant, an amendment may be filed as provided by 37 CFR 1.312. To ensure consideration of such an amendment, it MUST be submitted no later than the payment of the issue fee.

Authorization for this examiner's amendment was given in a telephone interview with Carl Reed on 4/13/06.

The application has been amended as follows:

Please enter all of the following changes to the claims:

1. (Currently Amended) In a server system capable of communicating with a payment entity, a carrier, and a client computer associated with a health care provider, a method of

advancing payment for health care services rendered by the health care provider, in response to an insurance claim, and prior to the carrier making payment on the insurance claim, the method comprising the acts of:

receiving an insurance claim from a client computer, the insurance claim including patient information, insurance information, and treatment information;

determining by a server system whether the insurance claim is eligible for advance payment by determining:

whether the treatment information corresponds to health care services that are approved for payment using an accepted medical practice database, and

whether the patient is an approved beneficiary of the carrier using a patient eligibility database;

transmitting, by the server system, claim information associated with the insurance claim to the payment entity, wherein, upon receiving the claim information, the payment entity advances a first portion of an advance payment to a first account accessible to the health care provider and a second portion of the advance payment to a second account prior to the carrier making payment on the insurance claim, wherein a remaining part of the second portion of the advance payment is credited to the first account after debiting the second portion for at least one of service fees, interest, or unpaid balances; ~~and~~

transmitting the insurance claim to the carrier;

receiving payment from the carrier at the payment entity after the carrier adjudicates the insurance claim; and

distributing the payment to the payment entity to pay , wherein, upon receiving the insurance claim, the carrier makes payment on the insurance claim to the payment entity after adjudicating the insurance claim, thereby paying for the money advanced to the health care provider.

6. (Currently Amended) In a system comprising a client computer, a remote server computer, a payment entity, a carrier, and a financial entity, a method of paying a health care provider for rendered health care services before an insurance claim for the rendered health care services can be processed by the carrier, the method comprising the acts of:

receiving, at the client computer, patient information, insurance information, and treatment information entered by a health care provider to a computer-displayable claim form displayed by the client computer;

transmitting an insurance claim that includes the patient information, insurance information, and treatment information from the client computer to the remote server computer;

determining, by the remote server computer, whether the insurance claim is eligible for advance payment, wherein the insurance claim is revised at the client computer if the insurance claim is not eligible for advance payment until the remote server computer determines that the insurance claim is in condition for advance payment;

transmitting claim information from the remote server computer to the carrier and to the payment entity;

determining by the payment entity how much money should be advanced for the rendered health care services and determining how that money should be distributed;

transmitting a fund distribution request from the payment entity to the financial entity prior to the carrier adjudicating the insurance claim; ~~and~~

distributing, by the financial entity, credit between an operational account that is accessible to a provider and a reserve account that is not accessible to the provider;

debiting ~~, wherein~~ a portion of the credit in the reserve account ~~is debited~~ at least for service fees; and

crediting ~~then~~ a remaining part of the portion of the credit in the reserve account ~~is credited~~ to the operational account after the claim is adjudicated by the carrier.

22. (Currently Amended) In a client computer capable of communicating with a remote server computer that is in communication with a payment entity, a method of interactively preparing an insurance claim that is eligible for advance payment for health care services performed on a patient, the method comprising the acts of:

generating a computer-displayable claim form for display to a health care provider on a client computer;

receiving patient information, insurance information, and treatment information entered to the claim form by the health care provider at the client computer;

transmitting an insurance claim that includes the patient information, insurance information, and treatment information from the client computer to the remote server computer;

receiving information at the client computer from the remote server computer indicating to the health care provider that the insurance claim is not in allowable condition for advance payment, the information having been received in response to the remote server computer determining whether the treatment information corresponds to health care services that are approved for payment; and

revising the insurance claim by amending at least one of a diagnosis code or a treatment code; ~~and~~

transmitting the revised insurance claim from the client computer to the remote server computer to determine whether said revised insurance claim is in allowable condition for advance payment;

providing ~~, wherein the remote server computer provides~~ said revised insurance claim to a payment entity that issues a fund distribution request to a financial entity prior to a carrier adjudicating the revised insurance claim, the fund distribution request dividing the advance payment between an operational account accessible to the health care provider and a reserve account that is not accessible to the health care provider;

~~wherein~~ debiting a portion of the advance payment in the reserve account ~~is debited~~ for at least one of service fees, interest, and unpaid balances; and

~~then~~ transferring a remaining part of the portion of the advance payment ~~is transferred~~ to the operational account after the carrier adjudicates the claim corresponding to the advance payment.

36. (Currently Amended) A computer program product for implementing, in a server system that communicates with a client system, a payment entity and a carrier, a method of informing a health care provider who uses the client computer whether an insurance claim for health care services rendered to a patient is approved for advance payment, the computer program product comprising: a computer-readable medium carrying computer-executable instructions for implementing the method, the computer-executable instructions comprising:

program code means for receiving an insurance claim that includes patient information, insurance information, and treatment information from the client computer, the patient information, insurance information, and treatment information having been entered to the client computer by a health care provider;

program code means for determining whether the insurance claim is eligible for advance payment, by:

determining whether the treatment information corresponds to health care services that are approved for payment, and

determining whether the patient is a beneficiary of the carrier;

program code means for initiating transmission of reply information to the client computers the reply information indicating to the health care provider whether the insurance claim is eligible for advance payment;

program code means for initiating transmission of co-payment information to the client computer that indicates how much money the client owes as a co-payment for rendered health care services;

program code means for performing, if the reply information indicates that the insurance claim is not in condition to be paid, the acts of:

receiving a revised insurance claim; and

determining whether the revised insurance claim is eligible for advance payment, wherein at least one of a diagnosis code or a treatment code included in the treatment information has been revised at the client computer; and

program code means for performing, if the reply information indicates that the insurance claim is in condition to be paid, the acts of:

transmitting claim information to the carrier for processing the claim;

transmitting claim information to the payment entity for determining how much money to advance to the health care provider and for determining how to distribute the money prior to the carrier adjudicating the insurance claim to a first account accessible to the provider and a second account that is not accessible to the provider;

debiting ~~, wherein~~ the second account ~~is debited~~ for at least service fees;

crediting ~~and~~ any remaining money in the second account ~~is then credited~~ to the first account when the corresponding claim is adjudicated by the carrier;

receiving financial information from the payment entity that indicates how much money will be advanced to the health care provider; and

transmitting to the client system the financial information that indicates how much money will be advanced to the health care provider.

40. (New) In a server system capable of communicating with a payment entity, a carrier, and a health care provider, a method of advancing payment for health care services rendered by the health care provide, the method comprising:

receiving an insurance claim that includes patient information, insurance information , and treatment information from the provider;

determining that the insurance claim is eligible for advance payment prior to receiving payment from the carrier by:

determining that a patient is eligible for health care services;

determining if the claim includes services that are approved for payment by the carrier; and

comparing a diagnosis code and a treatment code with a compilation of accepted medical procedures to determine is the claim is eligible for advance payment; and

transmitting claim information to a payment entity for distribution of an advance payment to an operational account that is accessible to the provider and a reserve account that is not accessible to the provider;

distributing a first portion of the advance payment to the operational account and a second portion of the advance payment to the reserve account;

debiting the reserve account for at least one of service fees, interest, or unpaid balances owed by the provider after the carrier makes payment for the insurance claims; and

crediting ~~, wherein~~ a remaining amount in the reserve account ~~is credited~~ to the operational account after the reserve account is debited for at least one of service fees, interest, or unpaid balances owed by the provider and after the carrier makes payment for the insurance claim.

REASONS FOR ALLOWANCE

4. The following is an examiner's statement of reasons for allowance. Claims 1-27 and 36-40 (renumbered 1-32).

Claim 1 is directed towards a method for advancing payment for health care services rendered by a health care provider comprising: transmitting, by the server system, claim information associated with the insurance claim to the payment entity, wherein, upon receiving the claim information, the payment entity advances a first portion of an advance payment to a first account accessible to the health care provider and a second portion of the advance payment to a second account prior to the carrier making payment on the insurance claim, wherein a remaining part of the second portion of the advance payment is credited to the first account after debiting the second portion for at least one of service fees, interest, or unpaid balances; transmitting the insurance claim to the carrier; receiving payment from the carrier at the payment entity after the carrier adjudicates the insurance claim; and distributing the payment to the payment entity to pay for the money advanced to the health care provider.

The closest prior art of record, Boyer et al. (6,208,973) teaches a patient settling an adjudicated settlement transaction, where the Internet bank functions as a credit card merchant bank and debits the cardholder's credit account against the healthcare provider's payable via the credit card network, where the Internet bank executes a direct deposit of funds in the healthcare provider's account. The healthcare provider receives payment of the part of the healthcare transaction that the patient is responsible for. The Internet bank then exchanges data with the third party payor (insurance company), where the data is adjudicated by the adjudication engine. The Internet bank then transfers the healthcare provider's payable from the third party payor's account to a disbursement account and then the Internet bank transfers the third party payor's receivable from the disbursement account of the Internet bank for distribution to the healthcare

provider's bank account. See col. 10 line 35 to col. 11 line 18 for the discussion of these features.

However, Boyer fails to teach transmitting, by the server system, claim information associated with the insurance claim to the payment entity, wherein, upon receiving the claim information, the payment entity advances a first portion of an advance payment to a first account accessible to the health care provider and a second portion of the advance payment to a second account prior to the carrier making payment on the insurance claim, wherein a remaining part of the second portion of the advance payment is credited to the first account after debiting the second portion for at least one of service fees, interest, or unpaid balances; transmitting the insurance claim to the carrier; receiving payment from the carrier at the payment entity after the carrier adjudicates the insurance claim; and distributing the payment to the payment entity to pay for the money advanced to the health care provider.

Claims 2-5 incorporate the features of claim 1, and are allowed for the same reasons given above.

Claim 6 is directed to a method comprising: determining, by the remote server computer, whether the insurance claim is eligible for advance payment, wherein the insurance claim is revised at the client computer if the insurance claim is not eligible for advance payment until the remote server computer determines that the insurance claim is in condition for advance payment; transmitting claim information from the remote server computer to the carrier and to the payment entity; determining by the payment entity how much money should be advanced for the rendered health care services and determining how that money should be distributed; transmitting a fund distribution request from the payment entity to the financial entity prior to the carrier

adjudicating the insurance claim; distributing, by the financial entity, credit between an operational account that is accessible to a provider and a reserve account that is not accessible to the provider; debiting, a portion of the credit in the reserve account at least for service fees; and crediting a remaining part of the portion of the credit in the reserve account to the operational account after the claim is adjudicated by the carrier.

The closest prior art of record, Boyer et al. (6,208,973) teaches a patient settling an adjudicated settlement transaction, where the Internet bank functions as a credit card merchant bank and debits the cardholder's credit account against the healthcare provider's payable via the credit card network, where the Internet bank executes a direct deposit of funds in the healthcare provider's account. The healthcare provider receives payment of the part of the healthcare transaction that the patient is responsible for. The Internet bank then exchanges data with the third party payor (insurance company), where the data is adjudicated by the adjudication engine. The Internet bank then transfers the healthcare provider's payable from the third party payor's account to a disbursement account and then the Internet bank transfers the third party payor's receivable from the disbursement account of the Internet bank for distribution to the healthcare provider's bank account. See col. 10 line 35 to col. 11 line 18 for the discussion of these features.

However, Boyer fails to teach determining, by the remote server computer, whether the insurance claim is eligible for advance payment, wherein the insurance claim is revised at the client computer if the insurance claim is not eligible for advance payment until the remote server computer determines that the insurance claim is in condition for advance payment; transmitting claim information from the remote server computer to the carrier and to the payment entity;

determining by the payment entity how much money should be advanced for the rendered health care services and determining how that money should be distributed; transmitting a fund distribution request from the payment entity to the financial entity prior to the carrier adjudicating the insurance claim; distributing, by the financial entity, credit between an operational account that is accessible to a provider and a reserve account that is not accessible to the provider; debiting, a portion of the credit in the reserve account at least for service fees; and crediting a remaining part of the portion of the credit in the reserve account to the operational account after the claim is adjudicated by the carrier.

Claims 5-21 incorporate the features of claim 6, and are allowed for the same reasons given above.

Claim 22 is directed to a method comprising: transmitting the revised insurance claim from the client computer to the remote server computer to determine whether said revised insurance claim is in allowable condition for advance payment; providing, said revised insurance claim to a payment entity that issues a fund distribution request to a financial entity prior to a carrier adjudicating the revised insurance claim, the fund distribution request dividing the advance payment between an operational account accessible to the health care provider and a reserve account that is not accessible to the health care provider; debiting a portion of the advance payment in the reserve account for at least one of service fees, interest, and unpaid balances; and transferring a remaining part of the portion of the advance payment to the operational account after the carrier adjudicates the claim corresponding to the advance payment.

The closest prior art of record, Boyer et al. (6,208,973) teaches a patient settling an adjudicated settlement transaction, where the Internet bank functions as a credit card merchant

bank and debits the cardholder's credit account against the healthcare provider's payable via the credit card network, where the Internet bank executes a direct deposit of funds in the healthcare provider's account. The healthcare provider receives payment of the part of the healthcare transaction that the patient is responsible for. The Internet bank then exchanges data with the third party payor (insurance company), where the data is adjudicated by the adjudication engine. The Internet bank then transfers the healthcare provider's payable from the third party payor's account to a disbursement account and then the Internet bank transfers the third party payor's receivable from the disbursement account of the Internet bank for distribution to the healthcare provider's bank account. See col. 10 line 35 to col. 11 line 18 for the discussion of these features.

However, Boyer fails to teach transmitting the revised insurance claim from the client computer to the remote server computer to determine whether said revised insurance claim is in allowable condition for advance payment; providing, said revised insurance claim to a payment entity that issues a fund distribution request to a financial entity prior to a carrier adjudicating the revised insurance claim, the fund distribution request dividing the advance payment between an operational account accessible to the health care provider and a reserve account that is not accessible to the health care provider; debiting a portion of the advance payment in the reserve account for at least one of service fees, interest, and unpaid balances; and transferring a remaining part of the portion of the advance payment to the operational account after the carrier adjudicates the claim corresponding to the advance payment.

Claims 23-27 incorporate the features of claim 22, and are allowed for the same reasons given above.

Claim 36 is directed to a method comprising: transmitting claim information to the carrier for processing the claim; transmitting claim information to the payment entity for determining how much money to advance to the health care provider and for determining how to distribute the money prior to the carrier adjudicating the insurance claim to a first account accessible to the provider and a second account that is not accessible to the provider; debiting, the second account for at least service fees; crediting any remaining money in the second account to the first account when the corresponding claim is adjudicated by the carrier; receiving financial information from the payment entity that indicates how much money will be advanced to the health care provider; and transmitting to the client system the financial information that indicates how much money will be advanced to the health care provider.

The closest prior art of record, Boyer et al. (6,208,973) teaches a patient settling an adjudicated settlement transaction, where the Internet bank functions as a credit card merchant bank and debits the cardholder's credit account against the healthcare provider's payable via the credit card network, where the Internet bank executes a direct deposit of funds in the healthcare provider's account. The healthcare provider receives payment of the part of the healthcare transaction that the patient is responsible for. The Internet bank then exchanges data with the third party payor (insurance company), where the data is adjudicated by the adjudication engine. The Internet bank then transfers the healthcare provider's payable from the third party payor's account to a disbursement account and then the Internet bank transfers the third party payor's receivable from the disbursement account of the Internet bank for distribution to the healthcare provider's bank account. See col. 10 line 35 to col. 11 line 18 for the discussion of these features.

However, Boyer fails to teach transmitting claim information to the carrier for processing the claim; transmitting claim information to the payment entity for determining how much money to advance to the health care provider and for determining how to distribute the money prior to the carrier adjudicating the insurance claim to a first account accessible to the provider and a second account that is not accessible to the provider; debiting, the second account for at least service fees; crediting any remaining money in the second account to the first account when the corresponding claim is adjudicated by the carrier; receiving financial information from the payment entity that indicates how much money will be advanced to the health care provider; and transmitting to the client system the financial information that indicates how much money will be advanced to the health care provider.

Claims 37-39 incorporate the features of claim 36, and are allowed for the same reasons given above.

Claim 40 is directed to a method comprising: transmitting claim information to a payment entity for distribution of an advance payment to an operational account that is accessible to the provider and a reserve account that is not accessible to the provider; distributing a first portion of the advance payment to the operational account and a second portion of the advance payment to the reserve account; debiting the reserve account for at least one of service fees, interest, or unpaid balances owed by the provider after the carrier makes payment for the insurance claims; and crediting a remaining amount in the reserve account to the operational account after the reserve account is debited for at least one of service fees, interest, or unpaid balances owed by the provider and after the carrier makes payment for the insurance claim.

The closest prior art of record, Boyer et al. (6,208,973) teaches a patient settling an adjudicated settlement transaction, where the Internet bank functions as a credit card merchant bank and debits the cardholder's credit account against the healthcare provider's payable via the credit card network, where the Internet bank executes a direct deposit of funds in the healthcare provider's account. The healthcare provider receives payment of the part of the healthcare transaction that the patient is responsible for. The Internet bank then exchanges data with the third party payor (insurance company), where the data is adjudicated by the adjudication engine. The Internet bank then transfers the healthcare provider's payable from the third party payor's account to a disbursement account and then the Internet bank transfers the third party payor's receivable from the disbursement account of the Internet bank for distribution to the healthcare provider's bank account. See col. 10 line 35 to col. 11 line 18 for the discussion of these features.

However, Boyer fails to teach transmitting claim information to a payment entity for distribution of an advance payment to an operational account that is accessible to the provider and a reserve account that is not accessible to the provider; distributing a first portion of the advance payment to the operational account and a second portion of the advance payment to the reserve account; debiting the reserve account for at least one of service fees, interest, or unpaid balances owed by the provider after the carrier makes payment for the insurance claims; and crediting a remaining amount in the reserve account to the operational account after the reserve account is debited for at least one of service fees, interest, or unpaid balances owed by the provider and after the carrier makes payment for the insurance claim.

The Examiner has also provided the Hogan reference (US 2005/0033604 A1). Hogan discloses a method for allowing a provider to be reimbursed by an insurance company comprising a. a first party, the patient, requesting a service from a second party, the provider, b. the first party providing relationship information about said first party's relationship with a third party, the insurance company, to the health care provider, c. the health care provider electronically communicating said relationship information to an insurance company to verify eligibility of the patient, d. the insurance company confirming eligibility of the patient in an asynchronous real-time mode and providing a predetermined fee schedule between the insurance company and the provider for services for the patient; e. the provider submitting a claim to the insurance company based on services to the patient; f. comparing the submitted claim to the relationship information concerning the patient's relationship with the insurance company, and g. adjudicating the claim in an asynchronous real-time mode and settling the claim by the insurance company authorizing the transfer of funds to the second party when said compared information is within guidelines established by the third party. (Fig. 2, par. 47-59, par. 65, 68-70, claim 1).

However, Hogan fails to teach the limitations of claims 6, 22, 36, and 40, namely, transmitting claim information to a payment entity for distribution of an *advance payment* to an operational account that is accessible to the provider and a reserve account that is not accessible to the provider; distributing a first portion of the *advance payment* to the operational account and a second portion of the advance payment to the reserve account; debiting the reserve account for at least one of service fees, interest, or unpaid balances owed by the provider after the carrier makes payment for the insurance claims; and crediting a remaining amount in the reserve account to the operational account after the reserve account is debited for at least one of service

fees, interest, or unpaid balances owed by the provider and after the carrier makes payment for the insurance claim. In addition, Hogan fails to teach transmitting claim information to the carrier for processing the claim; transmitting claim information to the payment entity for determining how much money to advance to the health care provider and for determining how to distribute the money *prior to the carrier adjudicating the insurance claim* to a first account accessible to the provider and a second account that is not accessible to the provider; debiting, the second account for at least service fees; crediting any remaining money in the second account to the first account when the corresponding claim is adjudicated by the carrier; receiving financial information from the payment entity that indicates how much money will be advanced to the health care provider; and transmitting to the client system the financial information that indicates how much money will be advanced to the health care provider.

Any comments considered necessary by applicant must be submitted no later than the payment of the issue fee and, to avoid processing delays, should preferably accompany the issue fee. Such submissions should be clearly labeled "Comments on Statement of Reasons for Allowance."

Conclusion

5. The prior art made of record and not relied upon is considered pertinent to Applicant's disclosure. The cited but not applied prior art teaches processing law firm out-of-pocket costs using a separate account (US 2004/0236613), claim schedule management system having a calculating unit which computes advance payment based on claim information (JP 2003022410 A), technique of registration for and direction of electronic payments in real-time (US

2002/0087469), technique for debit and credit triggering (US 2002/0087465), technique for electronic funds escrow (US 2002/0087461), loan advancing system (US 2005/0216315 A1), mortgage loan data processing system and method for a loan broker (US 2004/0002915 A1), electronic exchange apparatus and method (US 2002/0010685), automated debt payment system and method using ATM network (6,304,860), payment and transactions in electronic commerce system (6,029,150), transaction protection system (5,426,281), system and method for implementing and administering a mortgage plan (4,876,648), method and apparatus for executing cryptographically-enabled letters of credit (6,477,513), electronic exchange apparatus and method (US 2001/0047329), adjudication method and system (US 2002/0147678), electronic flex card adjudication system and method (US 2005/0033677), personal online banking with integrated online statement and checkbook user interface (5,903,881), automated claims settlement acceleration system (US 2003/0187695), system and method for prepaying for services or goods to be consumed at a future date (US 2002/0004782), e-commerce consumables (US 2004/0083185), electronic income tax refund early payment system (4,890,228, 5,193,057, and 5,963,921), fully-automated system for tax reporting, payment, and refund (6,202,052), (Overman, William and William McCormick, Setting Up a Law Practice, Practical Lawyer, v. 42, n.5, pp. 35-46, July 1996, File # 485, #00582784), and (Sean P. Sweeney, Murphy's Law in Different Cases, Lawyer's Fee Structures Vary, Patriot Ledger, June 27, 1998, File # 781, #03506094).

6. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Carolyn Bleck whose telephone number is (571) 272-6767. The

Examiner can normally be reached on Monday-Thursday, 8:00am – 5:30pm, and from 8:30am – 5:00pm on alternate Fridays.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached at (571) 272-6776.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).

7. **Any response to this action should be mailed to:**

Commissioner of Patents and Trademarks
Washington, D.C. 20231

Or faxed to:

(571) 273-8300	[Official communications]
(571) 273-8300	[After Final communications labeled "Box AF"]
(571) 273-6767	[Informal/ Draft communications, labeled "PROPOSED" or "DRAFT"]

Hand-delivered responses should be brought to the Knox Building, Alexandria, VA.

CB

CB
April 28, 2006

JOSEPH THOMAS
SUPERVISORY PATENT EXAMINER